

April 7, 2003

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M2-03-0739-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to \_\_\_ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

\_\_\_ is a 57-year-old gentleman who has chronic low back pain. Records indicate the patient underwent a lumbar laminectomy in 1989. He subsequently underwent lumbar laminectomy and fusion in 1994. Because of persistent pain, he had an anterior posterior fusion of L5/S1 in March of 1998. He developed a pseudoarthrosis and underwent a revision lumbar laminectomy of L4/5 in 1998. It appears this patient has had some type of infection requiring a lumbar incisional repair in January of 1999.

This patient has had chronic low back pain despite operative intervention. He is currently being seen by \_\_\_, specifically \_\_\_. He has undergone treatment with a tens unit as well as pain management.

In July of 2002, an MRI of the lumbar spine was performed. It demonstrated mild stenosis above his fusion with a solid appearing fusion at L5/S1. In August of 2002, he underwent lumbar epidural steroid injections.

In the winter of 2002, the patient complained of lower back pain keeping him up at night. His treating physician, \_\_\_\_, recommends a MRI of the lumbar spine to rule out scar tissue as well as possible chronic disc space infection.

#### REQUESTED SERVICE

A repeat lumbar MRI is requested for this patient.

#### DECISION

The reviewer disagrees with the prior adverse determination.

#### BASIS FOR THE DECISION

Based on the medical records, the requested lumbar MRI would be a reasonable and necessary diagnostic entity at this point. Please note this patient has had multiple surgeries of the lumbar spine to include a revision fusion. The patient has had a history of an infection and is now having persistent back pain consistent with a possible discitis versus osteomyelitis or recurrent disc injury. An MRI would be appropriate at this time.

\_\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

#### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of

Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 7th day of April 2003.**